

# Treatment Preferences (Goals of Care)

*(This section is optional, but recommended)*

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Specific Instructions to my Patient Advocate -

***When I am not able to decide or speak for myself, the following are my specific preferences and values concerning my health care:***

### Instructions:

- *Put your initials (or "X") next to the choice you prefer for each situation below.*

### TREATMENTS TO PROLONG MY LIFE

**If I reach a point where there is reasonable medical certainty that I will not recover my ability to know who I am, where I am, and I am unable to meaningfully interact with others:**

\_\_\_\_\_ I want all possible efforts to prolong life made on my behalf, even if it means I may remain on life-sustaining equipment, such as a breathing machine or kidney dialysis, for the rest of my life.

**OR**

\_\_\_\_\_ I want my health care providers to try treatments to prolong my life for a period of time. However, I want to stop these treatments if they do not help, or if they cause me pain and suffering.

**OR**

\_\_\_\_\_ I want to stop or withhold all treatments to prolong my life.

*In all situations, I want to receive treatment and care to keep me comfortable.*

\_\_\_\_\_ ***I choose not to complete this section.***

*(continues on next page)*

**Instructions:**

- Put your initials (or "X") next to the choice you prefer for each situation below.
- NOTE: This is NOT a "Do Not Resuscitate" (DNR) Order, which is a separate legal document. Talk with your personal healthcare provider if you would like a DNR Order.

## CARDIOPULMONARY RESUSCITATION (CPR)

**If my heart or breathing stops:**

\_\_\_\_ I **want** CPR in all cases.

OR

\_\_\_\_ I **want** CPR unless my health care providers determine that I have any of the following:

- An injury or illness that cannot be cured and I am dying.
- No reasonable chance of surviving.
- Little chance of surviving long term, and it would be hard and painful for me to recover from CPR.

OR

\_\_\_\_ I **do not want** CPR but instead want to allow natural death.

### Additional Specific Instructions

I want my Patient Advocate to follow these specific instructions, which may limit the authority previously described in General Instructions to My Patient Advocate.

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\_\_\_\_ *I choose not to complete this section.*

## Signature

*(If you are satisfied with your choice of Patient Advocate and with the Treatment Preferences guidance you have provided in this section, you need to sign and date the statement below.)*

**I am providing these instructions of my own free will. I have not been required to give them in order to receive care or have care withheld or withdrawn. I am at least eighteen (18) years old and of sound mind. These are my preferences and goals expressed and affirmed on the date below:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_